Communicable Disease UPDATE

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Adolescents and STD Prevention

The Division of STD Prevention, in collaboration with the Department of Education and The Medical Foundation, recently concluded a research project aimed at gathering information about STD/HIV knowledge and perceptions of sexually-active, urban, Black and Latino youth aged 15 to 19 years. The project also assessed their perception of access to and use of screening services in school-based health centers and other facilities. The information collected would be used to inform programs to increase awareness of STD screening services for this population.

The first phase of the project involved conducting focus groups and key informant interviews with school-based health center staff, community-based healthcare providers, health educators and youth. The goals of the focus groups were to:

- Increase understanding of population and patients served
- Gain insight into existing services and programs to promote sexual health and provider-patient interaction regarding sexual health
- Explore barriers, facilitators and motivators related to sexual health care services and information (such as cost, confidentiality, stigma, etc.)
- Assess where teens learn about sexuality and sexual health; who/what they consider to be trusted resources
- Explore male/female differences in seeking sexual health services and information
- Gain knowledge of teens' media and technology use
- Explore channels, formats and messages (through group review of existing campaign examples and potential campaign messages/concepts)

The interviews yielded more information than anticipated. In particular, the focus groups with young people offered a great deal of insight into experiences and perceptions about sexual health risks, relationships, adults as sources of information and perceived accessibility of services.

Peers and friends were often cited as motivators for accessing services; in fact, some teens reported not wanting to go for services unless they had a support person to go with them. However, at the same time, having peers observe them accessing services was seen as a barrier. While many participants acknowledged limited trust in information about sex and sexual health they get from other teens, their trust level in their

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New and Expanded Vaccine Recommendations for Children

Over the past several months, there have been a number of updates to childhood immunization recommendations. These changes are a result of expanded recommendations for the use of two currently licensed vaccines for hepatitis A and influenza, as well as the licensure of a new vaccine for rotavirus.

Hepatitis A Vaccine

The Advisory Committee on Immunization Practices (ACIP) has published expanded recommendations for hepatitis A vaccine. All children should now routinely receive hepatitis A vaccine at 1 year of age (12-23 months). Vaccination should be completed according to the licensed schedules (2 doses given at least 6 months apart). Previously, hepatitis A vaccine was only recommended for those children considered to be at high risk. Children who are not vaccinated by 2 years of age can be vaccinated at subsequent visits. However, organized catch-up campaigns of non-high risk children are not generally recommended. Since the fall of 2005, both hepatitis A vaccine formulations, VAQTA (Merck) and Havrix (GlaxoSmithKline) have been licensed for use in children beginning at 12 months of age. MDPH anticipates being able to supply hepatitis A vaccine for children age 12-23 months some time after July, 2006.

Influenza Vaccine

In February, 2006, acknowledging the full burden of disease experienced by children 2-5 years of age, the ACIP voted to expand the recommendations for routine influenza vaccination of young children to include those 24 to 59 months of age (the previous recommendation was only for children 6 to 23 months of age). The ACIP also expanded the recommendation to include household contacts and out-of-home caregivers of children 24-59 months of age. Influenza vaccine continues to be recommended for older children and adults who are in high risk groups. At the current time, MDPH is not able to provide influenza vaccine for these additional childhood cohorts.

Rotavirus Vaccine

Also in February of this year, the Food and Drug Administration licensed a live, oral, pentavalent rotavirus vaccine, RotaTeq®, manufactured by Merck. Rotavirus is a significant cause of

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Look Inside!

Epidemiology

Diseases Caused by Ticks or Mosquitoes

Summer is approaching, which means more time outdoors and greater exposure to ticks and mosquitoes. Cases of disease carried by ticks and mosquitoes have increased over the last few years. From 2004 to 2005, reports of Lyme disease in Massachusetts increased by over 40%, while eight human cases of eastern equine encephalitis (EEE) virus infection and six cases of West Nile virus (WNV) infection were reported in those two years.

Lyme disease, spread by deer ticks, accounts for 96% of reported tickborne disease in Massachusetts. Human granulocytic anaplasmosis (ehrlichiosis) and babesiosis, while less common, are also spread by deer ticks and can cause serious complications. Dog ticks can transmit Rocky Mountain spotted fever and tularemia, also potentially serious conditions.

Since ticks transmit disease causing agents when they attach to people and take a blood meal, avoiding ticks and tick bites is the simplest way to prevent disease. Long sleeves and long pants tucked into socks should be worn while in grassy or wooded areas. Using repellent containing DEET is safe and effective when applied to the skin and clothing of adults and children over 2 months of age. Repellents should always be used according to manufacturer's recommendations. Permethrin-containing products are known to kill ticks and mosquitoes on contact and are used on clothing. With either repellent, it is important to wash treated skin and clothes when returning indoors. Since the longer the tick is attached, the greater the chance that disease will be transmitted, it is important to check yourself and your children for ticks after spending time in an area likely to have ticks. Pay close attention to the neck, the groin, behind the knees, along the hairline, and the areas between the toes. Remove ticks with fine-point tweezers, grabbing as close to the skin as possible and pulling directly upward. Twisting or squeezing the tick, or using petroleum jelly, or burning cigarettes is never recommended.

Risk of viral diseases spread by mosquitoes (arboviruses), increases during the summer and early fall. The most significant arboviral diseases in Massachusetts are WNV infection and EEE. People infected with WNV often show no or very mild symptoms, but occasionally can have serious complications. EEE is very rare but has more noticeable symptoms, including high fever, stiff neck and headache. While not all mosquitoes carry these viruses, and the chances of being bitten by an infected mosquito are low, precautions should be taken to avoid mosquito bites. Mosquitoes are most active at dusk and dawn, so stay indoors during these hours, or wear long sleeves and long pants. Use repellents containing DEET , picaridin, or oil of lemon eucalyptus (which is not recommended for children under 3) to reduce exposure to mosquitoes. Clothing can be treated with permethrin. Around your home, make sure that holes in window and door screens are repaired, dispose of containers that collect water, and keep wading pools and wheelbarrows turned upside down when not in use.

If you have any questions or concerns about mosquito or tickborne diseases, please visit the Massachusetts Department of Public Health website at www.mass.gov/dph.

Timely Identification and Reporting of Meningococcal Disease

Meningococcal disease is an acute bacterial disease caused by *Neisseria meningitidis* and characterized by abrupt onset of fever, headache, nausea and often vomiting, stiff neck and frequently, rash. Even with early diagnosis, modern therapy and supportive measures, case-fatality rates remain around 10%.

The primary means for prevention of sporadic meningococcal disease is antimicrobial chemoprophylaxis of close contacts of cases as soon as possible but ideally <24 hours after identification of the index patient. In Massachusetts, identification of close contacts is typically rapid and the administration of prophylactic antibiotics timely. Secondary cases are rare.
It is critically important to report cases of possible meningococcal disease as soon as the diagnosis is considered. Recently, reporting delayed until culture confirmation resulted in a missed opportunity to prophylax a contact before onset of disease.

Both confirmed *and* suspect cases of meningococcal disease are immediately reportable to the local health department or MDPH so public health measures can be put into place as quickly as possible. Such timely notification and reporting is important in preventing secondary cases.

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Current and past issues of CD Update are available online at:
http://www.mass.gov/dph/cdc/update/comnews.htm

Contact Jacqueline Dooley at jacqueline.dooley@state.ma.us or (617) 983-6559 to have PDF versions emailed to you.

Tetanus, Diphtheria and Pertussis (Tdap) Vaccine for Adolescents and Adults

In the spring of 2005, two formulations of tetanus, diphtheria and pertussis (Tdap) vaccine were licensed for use as a single booster dose. GlaxoSmithKline's BOOSTRIX® is approved for use in persons 10–18 years of age. Sanofi pasteur's ADACEL™ is approved for use in persons 11–64 years of age. The Advisory Committee on Immunization Practices (ACIP) "Recommendation for the Use of Tdap Vaccine in Adolescents" was published in MMWR on February 23, 2006 (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5503a1.htm).

- Adolescents 13-18 years of age who have not yet received Td should also receive a single dose of Tdap.
- Adolescents 11-18 years of age who have already received Td are **encouraged** to receive a single dose of Tdap, to provide protection against pertussis, if they have completed the recommended childhood DTaP vaccination series.

The school immunization requirement for 1 dose of Td at entry into 7th grade has not changed. However, Tdap would satisfy this requirement.

Adults

ACIP has issued provisional recommendations for the routine use of a single dose of Tdap vaccine (ADACEL™), to replace a *single* dose of Td, in individuals 19-64 years of age who have not already received Tdap. In addition to routine use, adults who have close contact with an infant <12 months of age such as women in the immediate post-partum period, parents, grandparents <65 years of age and child-care providers, should receive a single dose of Tdap, ideally at least one month before close contact with the infant. This is called a "cocoon strategy" to protect the most vulnerable age groups.

In adults an interval of 2 years or more since the last dose of tetanus toxoid-containing vaccine is suggested. However a shorter interval can be used. Health care workers who perform direct patient care should receive a single dose of Tdap, as soon as possible, if they have not already, with priority given to those health care personnel who work with infants <12 months of age. Health care facilities should provide Tdap to maximize uptake.

At the current time MDPH is able to provide state-purchased Tdap vaccine for the routine immunization of **one** cohort of children 11–12 years old (those entering 7th grade). However, state-supplied vaccine *may* also be used for: 1) adolescents 13–18 years of age who have not yet received a Td vaccine; and 2) wound prophylaxis in adolescents. State-supplied Tdap should **not** be used for: 1) adolescents 11-18 years of age who have already received Td vaccine; or 2) those at increased risk of exposure and in outbreak settings. Providers will need to use privately purchased Tdap for these groups.

Health plans and insurance carriers have been informed of the groups for whom MDPH will be supplying Tdap vaccine and the need for providers to purchase Tdap vaccine to augment their state-supplied vaccine. The Current Procedural Terminology (CPT®) code for both BOOSTRIX® and ADACEL™ is 90715. Please note, MDPH will continue to provide Td vaccine.

A detailed advisory regarding Tdap vaccine recommendations for adolescents can be found on the MDPH website: http://www.mass.gov/dph/cdc/epii/imm/alerts/tdap_vaccine_advisory.pdf.

If you have questions about the recommendations for use of Tdap vaccine, school immunization requirements or the availability of state-supplied Tdap vaccine, please call the MDPH Immunization Program at 617-983-6800 or 888-658-2850.

Adapted from:

CDC. Preventing tetanus, diphtheria, and pertussis among adolescents: use of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccines. Recommendations of the Advisory Committee on Immunization Practices (ACIP) Appendix C. MMWR Early Release 2006;55(February 23, 2006):28,37-38.

CDC. ACIP Votes to Recommend Use of Combined Tetanus, Diphtheria and Pertussis (Tdap) Vaccine for Adults. March 2, 2006.

Mumps In Massachusetts

Since December 2005 and as of May 15, 2006, there have been over 5,800 cases of mumps reported nationwide and is the largest outbreak in the U.S. in 20 years. More than half of the cases are from Iowa and its neighboring states, including Illinois, Indiana, Kansas, South Dakota, Minnesota, Missouri, Nebraska and Wisconsin. Most of the cases have been persons 18-25 years of age, many of whom are vaccinated. However, all age groups have been affected. Many of the cases have occurred in college settings. In addition, 13 cases of confirmed mumps traveled on 33 different commercial airline flights between March 26, 3006 and May 2, 2006. Therefore, spread within the U.S. from the domestic outbreak, as well as exposures due to international travel, is likely. Mumps remains common in many parts of the world, including Western Europe.

Over the past few years, 1-3 cases of mumps have been reported in Massachusetts, with 7 cases reported in 2005. Two of the 2005 cases were imported from Western Europe and resulted in additional cases in under-immunized individuals.

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STD

STD/HIV Prevention Training Center of New England

The STD/HIV Prevention Training Center (PTC) of New England is one of ten sites across the nation funded by CDC to provide clinical training and information for health care providers in the prevention, diagnosis, treatment and management of sexually transmitted diseases and the prevention of HIV infection. The training center is part of the National Network of STD/HIV Prevention Training Centers (NNPTC), a vital resource providing clinical, behavioral, and partner management information and education for health professionals.

Since 1995, the PTC of New England has reached thousands of clinicians and laboratorians to provide them with the most up-to-date information on STDs. Trainings reach a broad group of new and experienced practitioners working in correctional health care, school-based and college health, primary care, family planning and adolescent health. Courses are designed to meet the needs of the busy clinician; needs assessments are conducted on an ongoing basis to elicit practice challenges, training needs and ideal training modalities for practitioners. Over the years, course content and training formats have changed to meet identified needs.

In 2006, the PTC was awarded another 5 years of funding from the CDC to continue to offer state-of-the-art courses for New England practitioners. Course offerings currently include laboratory training in conjunction with the National Laboratory Training Network (NLTN), intensive multi-day trainings offered in partnership with local STD clinics, on-site "Grand Rounds" and evening lectures. To meet the demand for training in Connecticut, the PTC also collaborates with the Hartford Health Department and offers training in Hartford on a regular basis. Laboratory courses are held at the State Laboratory Institute and include wet mount, Gram stain, and syphilis serology courses. The cornerstone of the program is a three-day intensive course offered at three different training sites: Massachusetts General Hospital, Boston Medical Center, and the Burgdorf/Fleet Health Center in Hartford. Intensive trainings are a combination of didactic lectures/case discussions and experiential learning, with hands-on laboratory and clinical time incorporated into course content. This year, the PTC entered into an exciting new collaboration with Brown University faculty to replicate our successful instructional models and bring STD information and training directly to clinicians in Rhode Island.

The PTC has also produced useful online and print resources for clinicians. A free online CME self study module, enhanced with clinical illustrations and video segments, is accessible at http://www.bu.edu/cme/std/; clinician toolkits have also been developed and are available in hardcopy and online at http://www.mass.gov/dph/cdc/stdtcmai/stdtcmai.htm. The following toolkits are available: "*Prevention and Management of Chlamydial Infections in Adolescents; Prevention and Management of STDs among Men who Have Sex with Men; and Managing STDs in the Correctional Setting: A Guide for Clinicians*".

It will be a busy 2006 for the PTC. In addition to monthly training activities, the PTC has developed and delivered specialized provider workshops on adolescent sexual health, has spearheaded an effort to deliver training to HIV/AIDS care providers based on CDC/NIH/IDSA guidelines of incorporating HIV prevention into the medical care of persons living with HIV, and will host a one-day women's health conference in Cambridge on June 23. *"Women's Health 2006: An Update on Management and Prevention of Sexually Transmitted Infections"* will feature national experts delivering the latest recommendations, including the 2006 CDC STD Treatment Guidelines.

For more information on the National Network of Prevention Training Centers, visit www.stdhivpreventiontraining.org. To access New England PTC course information, educational resources, and/or registration materials, visit www.state.ma.us/dph/cdc/stdtcmai/stdtcmai.htm or contact the PTC at 617-983-6945.

Mumps In Massachusetts

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Since January 2006, heightened surveillance has resulted in a significant increase in the number of cases investigated; every attempt is made to determine if there are links to the ongoing outbreak. MDPH has investigated over 70 suspect cases of mumps as of May 15, 2006, but only 2 have been confirmed.

Given the nature of the national outbreak, the MDPH is recommending: 1) child care centers, schools, colleges, camps and health care facilities carefully review the immune status of their attendees and employees to ensure that all are up-to-date for mumps vaccination, and 2) children 12-15 months of age should receive their first dose of MMR vaccine on time. Additionally, the MDPH asks that any suspect case of mumps is reported immediately to the local board of health and MDPH at (617) 983-6800.

Refugee and Immigrant Health

CLAS Standards and Public Health Services in Massachusetts

The population of U.S. is increasingly diverse and this diversity can present challenges to health care and public health. Racial and ethnic disparities in health status exist and access to and quality of care have been cited as contributing factors. As providers of health care seek to deliver care that is responsive to the cultures and languages of their patients, a systematic approach has been sought.

The Office of Minority Health, U.S. Department of Health and Human Services, facilitated a process of developing national standards for culturally and linguistically appropriate services (CLAS) in health care. These were published in draft form in the Federal Register and, following a period of public comment and further deliberation by an expert advisory committee, fourteen standards were finalized in 2000. The CLAS standards provide a framework to many stakeholder organizations and agencies – a framework that can be applied or adapted, as appropriate.

The standards are organized in three themes: Culturally Competent Care, Language Access Services, and Organizational Supports for Cultural Competence. Within each theme, the CLAS are as follows:

Culturally Competent Care

1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Language Access Services

4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/ consumer).
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Organizational Supports for Cultural Competence

8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS related activities.
13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Nationally, health care providers, including managed care organizations, have utilized CLAS in their efforts to address cultural competency. Now, the Department of Public Health's Center for Community Health, with leadership from its Office of

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Regionalization: The Way Forward for Training, Education & Medical Consultation

As we move public health into the Twenty-First Century, sharing resources, utilizing new technology and networking with experts increase effectiveness. One way to maximize resources is through regionalization. Key areas identified for regionalization of efforts to prevent and control tuberculosis are training, education and medical consultation. The Division of TB Prevention and Control of the Massachusetts Department of Public Health is a partner in the Northeastern Regional Training and Medical Consultation Consortium (RTMCC) of the Global TB Institute based in Newark, New Jersey. The Northeastern RTMCC has been funded by the Centers for Disease Control and Prevention (CDC) for the next five years to support, strengthen, and supplement training and medical consultation services in twenty project areas. The Northeastern RTMCC supports selected existing training in Massachusetts as well as the initiation of new training programs in other New England states.

The Massachusetts regional update conferences in the Southeastern and Western regions of the state will be Northeastern RTMCC-supported in 2006. As part of this agreement, individuals from neighboring states, in this case Connecticut and Rhode Island, will be invited to contribute to the training curriculum and attend the conferences. In addition, the Northeastern RTMCC supported a TB Clinician's Update conference held on April 8, 2006 in Salem, Massachusetts. Topics addressed included: TB epidemiology, laboratory procedures and diagnostic tests, legal and ethical issues in case management, TB/HIV, pediatric TB, TB in Kenya, TB clinical trials and new drug development and TB risk management. Nearly forty-five clinicians participated and program evaluations were very positive. The Northeastern RTMCC will also support two training programs in other New England states in the 2006 calendar year. For upcoming Northeastern RTMCC trainings, visit: http://www.umdnj.edu/ntbcweb/et_frame.html.

Another regional resource is Dr. Mark Lobato of the CDC Division of TB Elimination. Dr. Lobato is a Medical Epidemiologist for the New England region. Dr. Lobato has initiated online interactive web presentations titled "Eliminating TB Case By Case: A Case Series for Providers and Clinicians." This program caters to clinician's busy schedules, as each program is only an hour in length and can be accessed through any Internet-connected computer. In addition to the New England TB case series, Dr. Lobato is an expert on TB in correctional settings and pediatric TB, and he speaks at various conferences throughout the region on these topics. He is also fostering connections between New England TB programs through the initiation of a website to share programmatic issues and concerns that can be found at: www.NewEnglandTB.com.

In addition to programmatic collaboration and the support and/or initiation of training programs, regionalization holds a lot of potential for increased research. The Northeastern RTMCC has conducted an extensive needs assessment process to determine the education and medical consultation priorities for the region. This process involved questionnaires and interviews with state TB program staff and surveys of the end-users of education and training programs and medical consultation services. Through this process, individual state reports and an aggregate report for the region have been generated. Two independent surveys for end-users of medical consultation services have been generated in Massachusetts and New Hampshire. New Hampshire's survey is completed and they received over 400 responses (about a 30% response rate) from providers in the four highest incidence counties of the state. Massachusetts has sent out 6,600 hundred surveys and has received about 300 responses in the first week of the process. These surveys will help TB programs in New England evaluate their relationship with private providers and improve medical consultation services.

Overall, the Northeastern RTMCC and Dr. Lobato affords opportunities to explore new training methodologies, connect with other state TB programs and impact the process of regionalization. Regionalization offers many possibilities to utilize resources more effectively and efficiently both in Massachusetts and throughout the Northeast region. If you would like more information on regional activities pertaining to training and education in New England, please feel free to contact Erin Howe, Health Educator, RTMMC, at (617) 279-2137.

CLAS Standards and Public Health Services in Massachusetts

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Multicultural Health, is embarking on a process to develop standards for Massachusetts that are consistent with CLAS and that can be implemented throughout the Center's procurement and internal operations. With the involvement of the Bureau of Communicable Disease Control and other DPH Centers in the process, implementation may effect change in a wide range of activities and operations across public health. It is hoped that the systematic application of CLAS will present a tool to improve health outcomes in Massachusetts.

HIV/AIDS Among Asian/Pacific Islanders in Massachusetts

Categories typically used in the descriptive epidemiology of the HIV/AIDS epidemic in Massachusetts are white (not-Hispanic), black (not-Hispanic), Hispanic and other. Asian/Pacific Islanders (APIs) are often aggregated with "Other" because the numbers reported with HIV/AIDS are relatively small, and small numbers lead to difficulty interpreting rates and raise concerns about privacy (Table 1). In order to obtain a better perspective of the impact on HIV/AIDS on APIs in Massachusetts, the HIV/AIDS Surveillance Program examined trends over time.

Trends in Diagnosis of AIDS and HIV Infection

AIDS diagnoses among whites, blacks and Hispanics began to decline in the early 1990s and this trend continued through 2004 (Figure 1). There is no visible trend in AIDS diagnoses over time for API when plotted on the same scale (Figure 1, left Scale 1). However, a trend is noted when API AIDS cases are plotted against the scale on (Scale 2). The number of newly diagnosed AIDS cases among APIs increased each year throughout the 1990s, and did not begin to decline until 2001. Similar trends are apparent in Figure 2 (the number of reported new HIV infection diagnoses each year). When plotted against the scale on the right (Scale 2), the number of newly reported HIV infection diagnoses in APIs is seen to increase over time, with declines not being observed until after 2001.

AIDS Case Rates

Age adjusted rates of AIDS per 100,000 population have been higher among blacks and Hispanics in Massachusetts than in whites. While AIDS case rates among whites were declining throughout the 1990s and into the early 2000s, the AIDS case rate among APIs was increasing until it peaked and exceeded the rate in whites in 2000 (Figure 3). Additionally, although the AIDS case rate among APIs began declining after 2000, it exceeded that of whites again in 2002.

Trends in HIV/AIDS among API warrant concern about provision of services for API living with HIV/AIDS and the targeting of prevention strategies for this diverse and multicultural population.

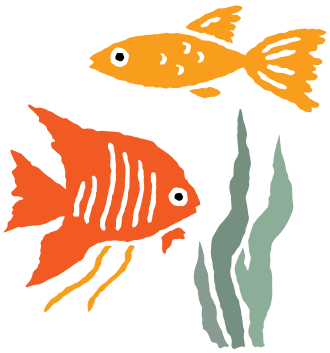
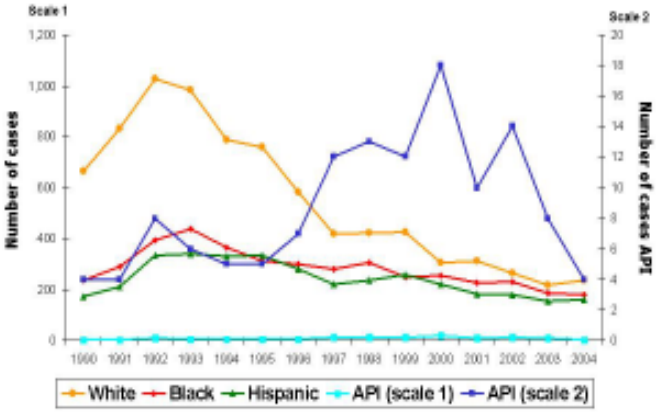
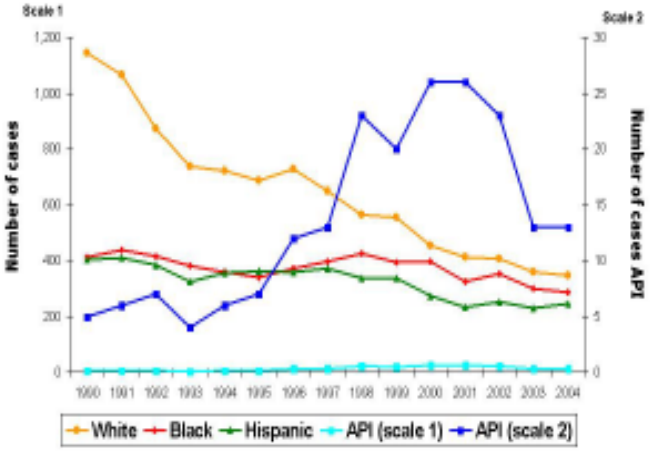


Figure 1. Reported AIDS Cases by Race/Ethnicity and Year of Diagnosis: MA, 1990-2004



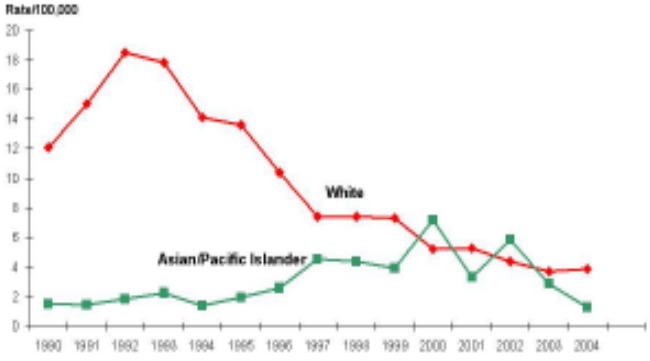
Data Source: MDPH HIV/AIDS Surveillance Program; Data as of 1/1/2006

Figure 2. Reported HIV Diagnoses by Race/Ethnicity and Year of Diagnosis: MA, 1990-2004



Data Source: MDPH HIV/AIDS Surveillance Program; Data as of 1/1/2006

Figure 3. Age-Adjusted AIDS Case Rate per 100,000 for Asian/Pacific Islanders and Whites by Year of Diagnosis: MA, 1990-2004



Data Source: MDPH HIV/AIDS Surveillance Program; Data as of 1/1/2006

Adolescents and STD Prevention

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own friends was generally very high. Many felt there was a major difference between information from other teens (in general) compared to information from their own friends.

Many teens acknowledged wanting more information, particularly more information about STDs, but didn't feel that they were getting it from parents, teachers or health care providers. Having to disclose sexual activity was seen as a barrier, particularly with providers. For some, there seemed to be an underlying desire not to expose themselves to a lecture from providers about all of the things they need to do (use condoms, get tested, use birth control, etc.) if they did disclose sexual activity.

While teens had mixed responses about their awareness of and willingness to access STD/HIV screening and care at a variety of health care sites, a large percentage of teens reported that they were unaware of where to go or refer a friend for sexual health services. Participants acknowledged that many teens do not see themselves at risk for STDs. Many attributed this low perception of risk to ignorance. Additionally, many participants framed risk in terms of promiscuity, cheating and overall sexual activity.

While many teens talked about accessing sexual health services for preventative reasons, many acknowledged that it is often an immediate need (STD symptoms or a missed period) that is the catalyst to walk through a provider's door. Teens have gotten the message that seeking services is a positive thing, which is good; but their perceived need for these services may still be tied to negative things (i.e., that something is "wrong".) Teens were quite straightforward that a campaign targeting them needs to highlight three things: services that are confidential, services that are free (or low-cost) and services/providers that are teen-friendly (non-judgmental, respectful, understanding of unique health needs of adolescents).

Based on information gathered during the first year of this project, the Division is currently working with its partners to develop a multi-faceted campaign to increase awareness of sexual health and STD screening services among the population surveyed. Services to be highlighted include school-based health centers as well as other reproductive and sexual health services, such as family planning services, STD clinics, and HIV counseling and testing sites.

New and Expanded Vaccine Recommendations for Children

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gastroenteritis in the United States, leading to many physician office and emergency room visits. Almost all children in the United States have been infected with rotavirus by their fifth birthday. RotaTeq® is approved for use in infants 6 to 32 weeks of age. The 3 dose series should be administered at 2, 4 and 6 months of age. The first dose should be given by 12 weeks of age and all doses must be administered by 32 weeks of age. There is no catch up schedule for children over 32 weeks of age. During clinical trials, RotaTeq® prevented 74% of all cases of rotavirus disease and 98% of severe disease.

RotaShield®, a different rotavirus vaccine, was withdrawn from the market in 1999 due to an association with bowel intussusception. However, no association has been identified between RotaTeq® and intussusception in pre-licensure clinical trials. Rates of intussusception will be monitored post licensure to assure there is no association. At the current time MDPH is not able to provide rotavirus vaccine. When federal funding from the Vaccines for Children (VFC) program is available, we do anticipate providing RotaTeq® to the children eligible for this entitlement program.

For questions regarding vaccine recommendations or the availability of vaccines, please call the MDPH Immunization Program at 617-983-6800 or 888-658-2850 or visit our website: http://www.mass.gov/dph/cdc/epii/imm/imm.htm.

Sources:
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